CSI Rhode Island
PCMH Successor Contract
Implemented April 1, 2011
Major Contract Elements

COMPENSATION

1. The Provider shall be paid the following per member per month payments ("PMPM") :

    a. Contract Year 1 (effective April 1, 2011 – March 31, 2012): Provider will be paid $5.50 PMPM for each Eligible Subscriber.
    b. Contract Year 2 (effective April 1, 2012 – March 31, 2013): Provider's Compensation will be paid at a scaled rate based upon performance in Contract Year 1:
        i. The Provider will be paid $5.00 PMPM for each Eligible Subscriber if no Target or only one Target is met; or
        ii. The Provider will be paid $5.50 PMPM for each Eligible Subscriber if Target #1 is met along with one other Target (Target #2 or Target #3); or
        iii. The Provider will be paid $6.00 PMPM for each Eligible Subscriber if all three Targets are met.

2. Payments made per member per month ("PMPM") will be made for Eligible Subscribers subject to the following definitions and requirements.

    a. Eligible Subscribers means Commercial Subscribers and Medicare Subscribers who receive coverage on a fully-insured basis or self-insured basis and who are entitled to receive Covered Health Services as described in their respective Subscriber Agreements pursuant to the benefit programs underwritten or marketed by the Plan;

    b. Only Eligible Subscribers that either through self selection or, in the absence of self selection, through assignation to a Practioner through an attribution methodology to a physician or Practitioner listed in Section I.A., shall qualify as counting for purposes of the PMPM payments hereunder.

    c. Each Quarter the CSI attribution methodology for Eligible Subscribers (see Section IV d.2 for reporting requirements regarding Eligible Subscribers) will be defined as:

        i. Using the most recent 24 months of claims data, the PCP with the ***most recent*** well visit (CPT codes: 99381-99387, 99391-99397) is attributed as the PCP for the Eligible Subscriber; if there is no well visit, then,

ii. the physician with the ***greatest number*** of sick visits (CPT codes: 99201-99205, 99211- 99215) is attributed as the Eligible Subscriber's PCP. In the event of two or more PCP's have the same number of sick visits, the PCP with the most recent sick visit will be attributed as the Eligible Subscriber's PCP.

iii. A PCP is defined as a primary care physician as credentialed by the Plan with a specialty in Internal Medicine or Family Practice (or any midlevel practitioners employed by the Internal Medicine or Family Practice practice providing primary care services).

3. PMPM payments for Eligible Subscribers (as defined in Sections A –B above) shall be made to Provider prospectively on a quarterly basis and no later than the third week of the first month of each quarter.

4. Nurse Care Managers ("NCM"). NCMs will be hired by the Provider to support the implementation and maintenance of the Patient Centered Medical Home ("PCMH") elements including but not limited to the coordination of care. Compensation for the NCM is included in the PMPM payments outlined in Section II.A. It is the expectation that the Provider will have a dedicated NCM retained to sufficiently support these types of functions listed in Attachment A. If at any time the Provider reasonably expects to be without a NCM for a period of 30 days or more, the Provider will notify the CSI Steering Committee and the Plan. If more than 90 days passes and the Provider has not been able to replace the NCM, the parties will attempt to reach a mutually agreeable alternative arrangement to replace the services provided by the NCM. However, if a mutually agreeable alternative is not agreed upon, the Plan will have the unilateral right to reduce the PMPM by an amount of no more than $1.25 or terminate this Agreement with the Provider.

5. "Target" refers to the three (3) measures outlined in Section II.F.1. – F.3 below; specifics related to the definitions of the metrics and how performance will be measured are outlined in this Agreement. Target #1 and Target #2 will be measured based on the aggregate performance of CSI Providers as described under Section I A. and B. of this Agreement; Target 3 will be measured based on the Provider's sole performance. (See Section VIa. For procedures to be used in case of disputes in the calculation of Target results).

6. Target #1: Utilization Metric (CSI Provider metric):

    a. CSI Providers will achieve a five percent (5%) relative reduction in hospital admissions per thousand as compared to similar, non –PCMH providers during the same measurement period. "Non-PCMH providers" will be defined and agreed to through the CSI collaboration process and agreed to by the CSI Steering Committee.

        i. For example, if the comparison non- PCMH providers have a rate of 45 hospital admission / 1000, CSI Providers will achieve a rate of 42.75 admissions / 1000 to meet target: (45 – [45 X .05] = 42.75)

b. CSI Providers will achieve ten percent (10%) relative reduction in ED visits per thousand as compared to similar, non –PCMH providers during the same measurement period.

    i. For example, if the comparison non- PCMH providers have a rate of 330 ED visits/ 1000, hospital admission / 1000, CSI Providers will achieve a rate of 297 visits / 1000 to meet target: (330 – [300 X .10] = 297)

c. Target #1 will also be considered met if either 1.a. or 1.b. measure exceeds target by one point or more and 75% or more of the other target is achieved.

d. Target #1 is an annual measure and will be based on comparison utilization activity for Calendar Year 2010 ("Base Year") as compared to the Calendar Year 2011 ("Performance Year"). The performance results shall be created and reported as follows:

e. Plan shall provide to the CSI Project Management sufficient claims detail by product to support the reporting for the Inpatient and ER metrics as identified in Target #1. The specific data requirements will be defined by the Reporting and Data Committee with approval by the CSI Steering Committee no later than December 31, 2011.

7. Target # 2: Quality and Member Satisfaction Improvement (Provider Metric):

    a. Quality: Provider will achieve the target on three out of the six CSI clinical quality measures as defined in Attachment B: Target #2 Reporting and Measurement. If the benchmark is not achieved, the target will also be considered as met if the Provider achieves half the distance between the baseline rate and the target, as long as half the distance equals at least a 2.5 % point improvement. The quality measures are based on industry- standards metrics.

    b. Member Satisfaction: Provider will conduct and present findings to Plan by end of Year 1 (March 31, 2012) of its member satisfaction survey that demonstrates achievement of greater than eighty percent (80%) average "satisfied" or "very satisfied" rate. The Provider's selected validated tool shall be submitted to Plan and approved within 30 days of the execution of this Agreement.

8. Target # 3: Process Improvement (Provider Metric): Provider will demonstrate to the Plan's satisfaction successful implementation and maintenance of the following Process Improvement metrics:

    a. After Hours: The Provider will submit to the Plan for Plan's approval the Provider's After Hours Protocol. The protocol for the Provider will include, the strategy for accessing weekend & extended hours of care location, hour of operations and protocols outlining how for Provider's Eligible Subscribers can access of care from these sites as an alternative to emergency room care. Provider will need to demonstrate to Plan's satisfaction the justification for the selected location and hours of operations; Plan's approval will not be unreasonably withheld. The approved After Hours Program must be in operation no later than October 1, 2011. The quarterly reporting requirements are to

be developed and approved by the CSI-RI Steering Committee ("Steering Committee") such that the first reporting occurs no later than the end of Quarter 4.

b. Hospital – Outpatient transition best practices: compliant with the Quality Partners of Rhode Island, "HOSPITAL & COMMUNITY PHYSICIAN BEST PRACTICES" (see Attachment D): as updated from time to time.

c. Compacts **with** high volume specialists: Provider will establish compacts consistent with Attachment E.: "Colorado Primary Care - Specialty Care Compact" and "American College of Physicians Council of Subspecialty Societies (CSS) Patient-Centered Medical Home (PCMH) Workgroup" such that one (1) compact is established and approved by the Plan by June 30, 2011. Two (2) additional compacts are established by the Provider and approved by the Plan by September 30, 2011 and a total of no less than four (4) compacts with four (4) different specialties shall be established by December 31, 2011 and maintained for the term of this Agreement. One of the compacts must be with a hospitalist unless Provider provides inpatient care for all of Providers' Eligible Subscribers at the Provider's primary hospital Eligible Subscribers receive inpatient services

9. Provider must also meet the NCM quarterly reporting requirements that will be developed and approved by the Steering Committee no later than August 31, 2011.

10. If at any time during this Agreement a Provider does not meet the minimum requirements as outlined by this Agreement, the Plan has the right to adjust the funding accordingly and /or terminate the funding associated with the Provider's participation in the program. Partial payments will not be made for partial achievement unless otherwise defined in this Agreement.

OTHER PERFORMANCE REQUIREMENTS

A. Physician Practice Connections ® – Patient-Centered Medical Home version Standards ("PPC-PCMH Standards"): The Provider shall maintain Level 3 recognition as defined by the Physician Practice Connections ® – Patient-Centered Medical Home version Standards ("PPC-PCMH standards"), during the term of this agreement in order to receive the compensation as outlined in Section II - Compensation.

TRAINING AND REPORTING

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A. The Provider shall participate in training as established by a training and support entity selected by the voting members of the CSI-RI Steering Committee. If at any time Provider fails to meet the training requirements, PMPM payments as defined in Section II Compensation herein shall be eliminated until such time as training requirements are completed. Completion status will be determined by the voting members of the CSI-RI Steering Committee

B. The Provider shall endeavor to engage its patients in the CSI-RI program. Patient Engagement is defined as communication from the Provider to an Eligible Subscriber about the PCMH initiative

and the additional services that are made available. Patient Engagement shall be measured by documentation in the Subscriber's medical record.

C. The Provider and, at the Plan's discretion, the Plan will participate in evaluations of CSI-RI conducted by a reviewer mutually agreed upon by the parties hereto and the Steering Committee, and provide data or other information requested as part of the evaluation. The Plan agrees to comply with reasonable requests.

D. The Plan agrees to provide to CSI the following reports related to the Plan's Eligible Subscriber population:

1. Hospital Emergency Department (ED) visits / 1000 - Quarterly
2. Percentage of Eligible Subscribers with greater than two (2) ED visits within ninety (90) days - Quarterly
3. Hospital admissions / 1000 – Quarterly
4. Subscriber Panels – Quarterly
5. Subscriber Inpatient and ED Utilization – Weekly
6. Other reports as agreed to by the Plan

E. The Provider agrees to provide the following reporting consistent with Attachment C. Quarterly Reporting Due Dates unless specified otherwise in this Agreement:

1. Target #2 Quality and Member Satisfaction Improvement Measures:
2. Process Measures for the following:
   a. After Hours of Care
   b. Participation in Hospital – PCP Transition best practices
   c. Compacts established with four (4) specialty groups (including one compact with a hospitalist)
   d. Patient Satisfaction Survey
   e. Nurse Care Manager Activities

F. Reporting values will be rounded to the nearest tenth of a digit for measurement purposes related to the Targets.

G. Beginning Quarter 5, Plan will contribute to the RI "All Payer" data base, if available, and if Plan has sufficient claim detail to calculate the agreed upon CSI utilization metrics outlined in this Agreement.

H. Beginning Quarter 6, Plan will provide Provider, if applicable, quarterly high dollar imaging activity. Plan will include the number of tests ordered by category, Additional fields may be added at the Plan's discretion that represent the Provider's performance against national benchmarks.

I. Beginning Quarter 5, Plan will report to Provider three (3) additional measures selected through statewide "harmonization" which for purposes of this Agreement shall mean selecting measures that are consistent with the standard measures being used in various statewide initiatives related

to primary care. Measures will be determined by mutual agreement between the various plans in PCMH, the Providers and the Steering Committee through the harmonization process. Type of measures to be considered include:

1. Ambulatory Care Sensitive Admissions / 1000
2. Thirty (30) day hospital re-admissions
3. Ambulatory Care Sensitive ED visits

VI. TERM AND TERMINATION

A. This Agreement shall commence on April 1, 2011 and shall continue thereafter until March 31, 2013, unless this Agreement is earlier terminated as set forth in this Section VI. By mutual agreement, the contract may be extended to a third year "Contract Year 3" (defined as April 1, 2013 – March 31, 2014) that will include the compensation terms as outlined in Section II Compensation A.2.a) – c) and be (re)scaled based on the Contract Year 2 performance. The parties will initiate Contract Year 3 discussions no later than the beginning of Quarter 7 (October 2012) with the goal to reach agreement on an extension for Contract Year 3 no later than December 31, 2012.

B. The Provider and the Plan hereto encourage the prompt and equitable settlement of all disputes or grievances arising from or related to this Agreement except for items specified under the section on cause for termination of contract. The parties agree to negotiate their differences directly and in good faith. If resolution is not possible, the issue will be referred to the voting members of the CSI RI Steering Committee for review and comment. If the dispute or grievance is deemed irreconcilable following review by the voting members of the CSI RI Steering Committee, either party hereto may terminate this Agreement by providing the other party with not less than ninety (90) days' prior written notice of termination. Notwithstanding the above, this section is intended to apply only to disputes related to subject matters governed under this Agreement related to the PCMH program. Any other disputes between the parties shall be resolved pursuant to the dispute resolution terms contained in the underlying Agreement between the parties.

Attachment A: Nurse Care Manager Role and Responsibilities

- Complete initial patient assessment, including a comprehensive medical, psychosocial, and functional assessment of the patient, including in the home setting if needed.
- Provide detailed education about patient's specific chronic illness, including the pathology, signs and symptoms, complications, and medications used in treatment.
- Assure that screening tests are up to date.
- Utilize a multi-disciplinary team approach to address opportunities to plan and coordinate care.
- Help to arrange contact with ancillary personnel.
- Establish care management plans, interventions, treatment goals – including self-management goals, and contact schedules.
- Promote compliance with chronic care plan.
- Coordinate care and communicate with multiple providers, both within and external to the practice
- Review test results and tracks outcomes.
- Review patient compliance issues.
- Work one-on-one with patients.
- Arrange group visits.
- Leverage EMR / chronic disease registry reporting to prioritize patient follow-up.
- Identify and utilize cultural and community resources.
- Develop reporting (to be defined) on service volume, distribution of patients by plan, and types of services provided.
- Ensure open communication, regarding patient status, with physicians and office staff.
- Provide training to non-RN Quality Assistant and other practice staff as needed.
- Act as liaison to hospital, long-term care, specialists and home health representatives.
- Attend required training and collaboration sessions [i.e., learning sessions, outcomes congress, care management collaboration meetings, and practice team meetings] as scheduled.
- Train staff on motivational interviewing
- Interact and coordinate with hospital and other provider staff, when applicable in caring for the patients within the Patient Centered Medical Home.

Attachment B: Target #2 Reporting and Measurement

In order to successfully achieve Target #2, practices must:

1. Achieve the below Clinical Quality benchmarks for 3 out of the six clinical quality measures at the end of the measurement year; AND
2. Achieve an average score of "satisfied" or "very satisfied" on at least 80% of the items on the annual Patient Satisfaction survey in the measurement year.

Achieving Clinical Quality Benchmarks:

Practices can meet the Clinical Quality Benchmark in one of two ways. They will meet the benchmark if they:

1. Achieve the CSI benchmark value (see below) for the measurement year. For example, a practice would meet the CSI benchmark for April 2011 through March 2012 if their clinical quality report to CSI for that time frame meets or exceeds the CSI benchmark. If a practice exceeds the target for a rolling year prior to the March, 2012 date, but does not achieve the benchmark during the April 2011 – March 2012 time frame, they will not be considered to have met the target. OR

2. Improve their performance on a particular measure by at least 50% of the distance between their baseline performance and the CSI benchmark, as long as the difference between the practice's baseline and the CSI benchmark is greater than or equal to 5%. If the difference between a practice's baseline measure and the CSI benchmark is less than 5%, then the practice can only meet the benchmark by achieving the actual CSI benchmark value. Baseline performance will be the calendar year just prior to contract initiation (April 2010 through March 2011).

Achieving Clinical Quality Benchmarks:

Practices can meet the Clinical Quality Benchmark in one of two ways. They will meet the benchmark if they:

1. Achieve the CSI benchmark value (see below) for the measurement year. For example, a practice would meet the CSI benchmark for April 2011 through March 2012 if their clinical quality report to CSI for that time frame meets or exceeds the CSI benchmark. If a practice exceeds the target for a rolling year prior to the March, 2012 date, but does not achieve the benchmark during the April 2011 – March 2012 time frame, they will not be considered to have met the target; or,

2. Improve their performance on a particular measure by at least 50% of the distance between their baseline performance and the CSI benchmark, as long as the difference between the practice's baseline and the CSI benchmark is greater than or equal to 5%. If the difference between a practice's baseline measure and the CSI benchmark is less than 5%, then the practice can only meet the benchmark by achieving the actual CSI benchmark value. Baseline performance will be the calendar year just prior to contract initiation (April 2010 through March 2011).

    a. Improving their performance from 50% to 64% during the measurement year, thereby meeting the CSI benchmark value; or
    b. Improving their performance from 50% to 57% (half the distance between baseline and CSI benchmark value).

    If a practice's baseline performance on the same measure is 60% in the baseline year, then the practice can only meet the benchmark by improving their performance from 60% to 64%, because the distance between 60% and 64% is less than 5%.

3. Practices can meet three of the six benchmarks by either one of these methods, or any combination of the two methods.

CSI Benchmark Values

CSI Clinical Quality Measure*	CSI Benchmark Value
Diabetes patients with HbA1c < 8	64%
Diabetes patients with blood pressure <130/80	40%
Diabetes patients with LDL <100	47%
Coronary artery disease patients prescribed Beta blocker	80%
Patients 18 and older with documented screening for depression in the prior year	55%
Current smokers who received advice to quit in prior year	85%

*Detailed measurement specifications attached.

Description and Details for all CSI Measures:

Clinical Measure	Numerator	Denominator	Core / Optional
DM - A1C Testing	Number of active patients with diabetes, aged 18-75 years who had a resulted A1c value during the *(Reference: Data # 3)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Optional
DM - A1C Control	Number of active patients with diabetes, aged 18-75 years whose most recent A1c value was less than 8.0% as of reporting period 1/15/11, changed from 7.0% during the measurement year. *(Reference: Data # 6)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Core
DM - BP Measurement	Number of active patients with diabetes, aged 18-75 years who had a blood pressure measurement recorded during the measurement year. *(Reference: Data # 4)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Optional
DM - BP Control	Number of active patients with diabetes, aged 18-75 years whose most recent BP measurement was less than 130/80 mmHg during the measurement *(Reference: Data # 7)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Core
DM - LDL Testing	Number of active patients with diabetes, aged 18-75 years who had a resulted LDL value during the *(Reference: Data # 5)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Optional
DM - LDL Control	Number of active patients with diabetes, aged 18-75 years whose most recent LDL measurement less than 100 during the measurement year. *(Reference: Data # 8)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Optional
DM - Eye Exam	Number of active patients with diabetes, aged 18-75 years with documented retinal eye exam by an eye care professional during the measurement *(Reference: Data # 9)*	Number of active patients aged 18-75 years who have a diagnosis of diabetes *(ICD-9 Codes 250.xx)*. *(Reference: Data # 2)*	Optional
CAD - Beta Blocker Therapy	Number of active patients with CAD who were prescribed a beta-blocker therapy during the *(Reference: Data # 11)*	Number of active patients aged 35 years or older who have a diagnosis of CAD *(ICD-9 Codes 410.xx -* *(Reference: Data # 10)*	Core
Depression Screening	Number of active patients, 18 years or older, with depression screen documented using a validated screening tool (such as PHQ2) within the *(Reference: Data # 12)*	Number of active patients, 18 years or older. *(Reference: Data # 1)*	Core
Advising Smokers to Quit	Number of active patients identified as tobacco users who received advice from a health care professional to quit during the measurement year. *(Reference: Data # 14)*	Number of active patients, 18 years or older who are identified as tobacco users during the measurement year. *(Definition of Smoker - Any patient who when asked if they use any form of tobacco states yes, independent of volume or interval of use).* *(Reference: Data # 13)*	Core

Reporting Requirements:

1. Definition of Active Patient: Active Patients - Patients are active if they have been seen for an office visit in the past 2 years and are currently a patient in the practice. Patients who have transferred, passed away, and/or are no longer able to be reached meaning the patient's contact information results in no phone, no emergency contact person, and mail sent to the patient is returned to the sender (3 separate contact attempts must be made in order to satisfy this requirement if no longer able to be reached.)

1. Baseline performance will be the calendar year just prior to contract initiation (April 2010 through March 2011).

2. Data is based on a rolling year:

This table shows the specified timeframes that should be used for each report.

Report	Active Patients	Measurement Year
Report 9	4/1/09 - 3/31/11	4/1/10 - 3/31/11
Report 10	7/1/09 - 6/30/11	7/1/10 - 6/30/11
Report 11	10/1/09 - 9/30/11	10/1/10 - 9/30/11
Report 12	1/1/10 - 12/31/11	1/1/11 - 12/31/11
Report 13	4/1/10 - 3/31/12	4/1/11 - 3/31/12
Report 14	7/1/10 - 6/30/12	7/1/11 - 6/30/12
Report 15	10/1/10 - 9/30/12	10/1/11 - 9/30/12
Report 16	1/1/11 - 12/31/12	1/1/12 - 12/31/12

Attachment C: Reporting Due Dates

Reports are due 15 days following the close of the reporting period.

Report	Report Due Date
Report 9	4/15/2011
Report 10	7/15/2011
Report 11	10/15/2011
Report 12	1/15/2012
Report 13	4/15/2012
Report 14	7/15/2012
Report 15	10/15/2012
Report 16	1/15/2013

Attachment D
Quality Partners of Rhode Island: "Hospital & Community Physician Best Practices"

Attachment E:
Colorado Primary Care - Specialty Care Compact & “American College of Physicians Council of Subspecialty Societies (CSS) Patient-Centered Medical Home (PCMH)